Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
REZIK A SAQER MD

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-15-0853-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
November 07, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is to state that Rezik A. Saqer, M.D., is an Anesthesiologist specializing in Pain Management. When a patient comes in for a first time evaluation, a random drug test is performed in our office to determine if the patient is on narcotic medications or if there is any illegal drugs in the patient's system. The patient signs a narcotic contract with our facility and only uses the Pharmacy listed on that contract. The patient understands when signing this contract that if they violate any of the terms of their contract his will result in the termination of the patient/physician relationship … I am appealing to the Medical Fee Dispute Resolution at this time for reimbursement of fees for our service."

Amount in Dispute: $560.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The health care in dispute is a listed on the explanation of benefits (EOBs). The health care in dispute is urine drug testing. The requester has the burden of proof in medical fee dispute resolution. *See* Medical Case Contested Hearing No. 11155; Texas Workers' Compensation Commission issued Advisory 2003.-21 … *The requestor has waived its right to dispute resolution because the filing was late.*"

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 25, 2013 and October 24, 2013	CPT Code G0431	$560.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE)

- 225 – THE SUBMITTED DOCUMENATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION
- 758 – ODG DOCUMENTATION REQUIREMENTS FOR URINE DRUG TESTING HAVE NOT BEEN MET
- CAC-16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDCATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE)
- CAC-W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A RECONSIDERATION OR APPEAL
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLIAM WAS PROCESSED PROPERLY
- 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A RECONSIDERATION OR APPEAL
- 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
- CAC-18 – EXACT DUPLICATE CLAIM/SERVICE
- 878 – APPEAL (REQUEST FOR RECONSIDERATION) PREVIOUSLY PROCESSED. REFER TO RULE 133.250(H)
- 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED, UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is July 25, 2013 and October 24, 2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on November 07, 2014. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	1/30/15 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.